

Summary of Benefits



ALERT! Even if a provider orders a test or prescribes a treatment, the plan may not cover it. Please review this *Certificate of Coverage* or call Customer Service at 1-888-849-3681 if you have questions about benefits or limitations.

On the next several pages, you'll find a summary of your plan benefits, a convenient reference to help you find the information you need. For a complete understanding of how a benefit works, it is important that you also read the pages listed in the "For More Information" columns.

Not all benefits are listed; for services not listed, see the Table of Contents, the Index at the back of the book, or call UMP Customer Service at 1-888-849-3681.

In order to be covered, all services must be medically necessary (see the definition on pages 114–115).

If you see an unfamiliar term, see the alphabetical list of definitions on pages 107–122.



ALERT! If you have coverage under another health plan, see pages 57–62. If your other coverage is Medicare, see pages 63–68.

Deductibles and Limits

What is it?	How much is it?	What else do I need to know?	For more information: See page(s)
Medical deductible	\$250 per person (maximum of \$750 for a family of three or more)	<ul style="list-style-type: none"> You pay toward this deductible before the plan begins to pay. You don't have to pay the deductible for some services. Not all services count toward this deductible. 	6–7
Prescription drug deductible	\$100 per person (maximum of \$300 for a family of three or more)	<ul style="list-style-type: none"> You pay drug costs for Tier 2 and Tier 3 drugs until you reach this amount. The plan pays its share for Value Tier and Tier 1 drugs right away; you don't pay the deductible. 	37–38
Out-of-pocket limit (medical)	\$2,000 per person (maximum of \$4,000 for a family of two or more)	Not all services count toward this limit.	8–9
Annual plan payment limit	None	No limit to how much the plan pays per calendar year.	Not applicable
Lifetime plan payment limit	None	No limit to how much the plan pays over a lifetime.	Not applicable

How Much Will I Pay?

The table below describes how much you'll pay for services. Unless otherwise noted, all payment is based on the allowed amount, which is the fee accepted as payment by a preferred provider, and services are subject to the medical deductible. See the Summary of Benefits table on pages 12–15 for which type of service applies to specific services.

Type of Service	How Much You Pay
Standard Subject to the medical deductible: You must pay the first \$250 in covered services before the plan begins to pay.	How much you pay (your coinsurance) depends on the provider's network status: <ul style="list-style-type: none"> ▪ Preferred providers — You pay 15% of the allowed amount. ▪ Out-of-network providers — You pay 40% of the allowed amount; the provider may balance bill. ▪ Participating providers — You pay 40% of the allowed amount; the provider may not balance bill. Indicated by \$\$ in the myRegence.com provider directory.
Preventive Preventive services are not subject to the medical deductible (you don't have to pay your deductible before the plan pays).	How much you pay (your coinsurance) depends on the provider's network status: <ul style="list-style-type: none"> ▪ Preferred providers — You pay \$0: the plan pays in full. ▪ Out-of-network providers — You pay 40%; the provider may balance bill. ▪ Participating providers — You pay 40%; the provider may not balance bill.
Inpatient Subject to the medical deductible. <ul style="list-style-type: none"> ▪ Professional providers may contract separately from a facility. Even if a facility is preferred, a professional provider may not be. ▪ Most inpatient services require that your provider notify the plan upon admission (see page 50). Some services must be preauthorized by the plan; see pages 49–50. ▪ Inpatient services are subject to an inpatient copay and separate charges for professional services, such as doctor consultations and lab tests. See the specific benefit—for example, diagnostic tests—for how these related services are covered. <p>Services are considered inpatient only when you are admitted as an inpatient to a facility. See definition of "Inpatient Stay" on page 112.</p>	<p>The inpatient copay is \$200 per day at preferred facilities</p> <ul style="list-style-type: none"> ▪ Employees and retirees not enrolled in Medicare: \$600 maximum per calendar year. ▪ Retirees enrolled in Medicare: \$600 maximum per admission; no annual maximum. <p>Note: The inpatient copay does not count toward your medical out-of-pocket limit.</p> <p>When you are hospitalized (admitted to a preferred facility as an inpatient), you will pay:</p> <ul style="list-style-type: none"> ▪ Any remaining deductible; ▪ The inpatient copay; AND ▪ Your coinsurance for professional services; depends on the provider's network status as described under the Standard type of service, listed above. <p><i>If you receive non-emergency inpatient care at an out-of-network facility, you will pay according to the Standard benefit above.</i></p>
Outpatient Subject to the medical deductible.	If you receive services at a facility that offers inpatient services but you are not admitted as an inpatient, the services are covered as outpatient. See the specific benefit—for example, diagnostic tests—for how much you will pay.
Special Subject to the medical deductible.	These services have unique payment rules, which are described in the "How much will I pay?" column on pages 12–15.

What else do I need to know?

- ♦ Some services aren't covered; see pages 52–56 for a list of specific services not covered by the plan.
- ♦ You don't need a referral from the plan to see a specialist for most services. However, you will save money by seeing preferred providers, especially for preventive services; see page 5.
- ♦ Preexisting conditions: There is no waiting period; medically necessary services are covered from the day you enroll.

Summary of Benefits

Only certain services are listed in the table. For those not listed, see the alphabetical list of covered benefits on pages 16–35, check the Index, or call Customer Service at 1-888-849-3681.

Please read the pages listed in the “For more information” column for each benefit. Not all details are included in the table. We recommend that you also read:

- ♦ Services that require preauthorization (pages 49–50).
- ♦ Services for which your provider must notify the plan (page 50).
- ♦ Services that aren't covered: exclusions (pages 52–56).

Benefit/Service	How much will I pay? (See page 11 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Ambulance	Special: 20% of the allowed amount for preferred or out-of-network providers. Out-of-network providers may balance bill.	17, 52, 56	Covered only for a medical emergency. See page 114 for limitations.
Applied Behavior Analysis (ABA)	Standard	17, 49	Specific preauthorization requirements; see page 17.
Chemical Dependency Treatment			
Inpatient Services	Inpatient	18-19, 49, 50, 55, 65	Inpatient admission requires plan notification. Treatment in residential facilities requires preauthorization.
Outpatient Services	Standard	18-19, 50, 55, 65	May be subject to review for medical necessity. Some services require plan notification; see page 50.
Chiropractic Physician Services (Spinal and Extremity Manipulations)	Standard	33, 54	Limited to 10 visits per calendar year.

Benefit/Service	How much will I pay? (See page 11 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Contraceptive Services for Women	Preventive	23–24, 31	See pages 23–24 for which services are covered as preventive.
Diabetes Care Supplies	Special: Paid under the prescription drug benefit; see pages at right.	20–21, 49, 60–61, 64	See page 64 if Medicare is your primary coverage.
Diagnostic Tests, Laboratory, and X-Rays	Standard	21, 49–50, 52, 54, 56	Usually billed separately from related office visits or inpatient services.
Durable Medical Equipment, Supplies, and Prostheses	Standard	22–23, 35, 40, 49–50, 53, 54, 110	May require preauthorization; see pages 49–50.
Emergency Room (ER) <i>You pay a \$75 copay per visit (in addition to coinsurance)</i>	Standard plus the ER copay (\$75) You are usually billed separately for: <ul style="list-style-type: none"> ▪ Facility charges ▪ Professional (physician) services ▪ Lab tests, x-rays, and other imaging tests 	23, 114	If you are admitted as an inpatient directly from the ER, you won't owe the ER copay (but will pay the inpatient copay). Services determined not to be due to a medical emergency (page 114) are not covered in an emergency room setting.
Family Planning Services	Standard <i>Some contraceptive services are covered as preventive; see pages 23–24.</i>	23–24, 54	Not covered: <ul style="list-style-type: none"> ▪ Infertility services ▪ Reversal of sterilization
Hearing Aids	Special: Plan pays up to \$800.	25, 65	Limited to \$800 plan payment per 3 calendar years.
Hearing Exams, Routine	Preventive	25, 31, 65	One per calendar year.
Home Health Care	Standard	25–26, 34, 53, 54, 112, 113	See pages 25–26 for what is covered. Specific services are not covered; see exclusion 27 on page 53. Maintenance (page 113) and custodial (page 109) care are not covered.
Hospice Care (Includes respite care)	Special: Paid at 100% after meeting deductible.	26, 112, 120	Covered for terminally ill members for up to six months. Respite care is limited to \$5,000 per lifetime.

(continued on next page)

Summary of Benefits, continued

Benefit/Service	How much will I pay? (See page 11 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Hospital Services			
<i>Inpatient Services</i>	Inpatient	26–27, 29, 50, 53, 65	All inpatient services require plan notification (see page 50). Some services require preauthorization; see pages 49–50.
<i>Outpatient Services</i>	Standard	26–27, 29	Some services require preauthorization; see pages 49–50.
Immunizations (Vaccines)	Preventive (usually)	32, 54, 115	Covered under CDC recommendations; see page 32. <i>Not covered for travel or employment.</i>
Mammograms (Diagnostic)	Standard	27	Must be billed as diagnostic by the provider.
Mammograms (Screening)	Preventive	27	Not covered as preventive until age 40; see page 27. Covered once per calendar year.
Massage Therapy	Standard	27, 54	Limited to 16 visits per calendar year. Only preferred massage therapists are covered.
Mastectomy and Breast Reconstruction	Inpatient (Standard for related outpatient visits)	22, 27	All inpatient services require plan notification (see page 50).
Mental Health Treatment			
<i>Inpatient Services</i>	Inpatient	28, 50, 54, 65	Inpatient admission requires plan notification (see page 50). Treatment in residential facilities requires preauthorization.
<i>Outpatient Services</i>	Standard	28, 50, 54, 65	May be subject to review for medical necessity. Some services require plan notification; see page 50.
Naturopathic Physician Services	Standard	5, 28, 47, 53, 65	Herbs, vitamins, and other supplements are not covered.
Obstetric and Newborn Care	Inpatient (Standard for related outpatient visits) <i>Some breast pumps are covered as preventive; see page 29.</i>	29, 31	For non-routine services for the newborn, you may pay toward the baby's deductible or inpatient copay; see page 29.

Benefit/Service	How much will I pay? (See page 11 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Office Visits	Standard	30, 54	See page 31 for routine exams covered as preventive.
Physical, Occupational, Speech, and Neurodevelopmental Therapy	Standard <i>Inpatient services are billed separately from the inpatient copay.</i>	30, 50, 54, 113	Inpatient: 60 days maximum per calendar year. Outpatient: 60 visits maximum per calendar year.
Prescription Drugs	See "Your Prescription Drug Benefit" on pages 36–48.	36–48	
Preventive Care <i>Includes vaccines, routine exams, some screening tests</i>	Preventive	27, 29, 31–32, 47, 65, 119	Only certain services are covered as preventive; see pages 31–32. See pages 23–24 for contraception covered as preventive.
Skilled Nursing Facility	Inpatient <i>Some services may be billed separately (such as physical therapy).</i>	32, 50, 54, 55, 121	Maintenance (page 113) and custodial (page 109) care are not covered.
Spinal and Extremity Manipulations	Standard	33, 54	Limited to 10 visits per calendar year.
Surgery		20, 27, 30, 33, 49–50, 52, 53, 55, 56, 108, 120	See page 18 for coverage of bariatric surgery.
<i>Inpatient Services</i>	Inpatient		Some services require preauthorization (pages 49–50) or plan notification (page 50).
<i>Outpatient Services</i>	Standard		Some services require preauthorization (pages 49–50).
Tobacco Cessation Program	Preventive	34, 56	Only the <i>Quit for Life</i> program is covered. See page 34 for drugs and nicotine replacement supplies covered.
Vision Care (Related to Diseases and Disorders of the Eye)	Standard	35, 53, 54	
Vision Care Routine eye exams	Preventive	35, 53, 54	One per calendar year.
Vision Hardware Glasses, contact lenses	Special: Plan pays up to \$150; network status of provider does not matter.	35	Up to \$150 per 2 calendar years (resets every even year).
Well-Child Visits	Preventive	31–32	See pages 31–32.